APPENDIX 13:

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER
1910 Massachusetts Avenue, S.E., Bldg. 27
Washington, D.C. 20003

Telephone: 202-698-9001

Fax: 202-698-9101

15 September 2003

Charles C. Maddox, Esq.
Inspector General
Office of the Inspector General
717 14th St., NW
Washington, DC 20005

Dear Mr. Maddox:

This letter is my response to the draft of the inspection report by the Office of the Inspector General (OIG), captioned OIG No. 03-0011CM, concerning the inspection of the Office of the Chief Medical Examiner (OCME). I am enclosing the computer disk with the electronic copy of the draft report, onto which I have placed my comments and responses to both the recommendations and the supporting text. For convenience, I have added my comments in Track Changes, so they are highlighted from the original text. I am also enclosing copies of multiple documents either to answer specific sections of the report, or to support assertions in the remainder of this letter.

The draft report identifies a number of areas of deficiency in OCME. As my comments in the body of the report show, I agree with some of the recommendations and disagree with others. Before addressing any specific items or themes from the report, I would first like to place the assessment of the agency in the context of what has been accomplished during my tenure as Chief Medical Examiner.

When I assumed the position of Chief Medical Examiner in 1998, OCME was highly dysfunctional. It had been without stable leadership, had a substandard facility, and had no specific plans to rectify any of its major deficiencies. I have brought strong professional guidance to the staff, have set and enforced high standards for the core functions of the agency, and have established OCME as an Executive Branch agency now recognized both within the government and in the community. I acknowledge that there are still serious areas that need to be addressed, as noted in the inspection report. However, some of the major operational deficiencies have been overcome within the span of about five years, which is considered a baseline in any major change effort of an organization. Specific areas to be noted include:

- Completed renovations of almost the entire facility, including upgraded ventilation system (which is still being addressed), modernized autopsy suite and mortuary, increased office capacity, newly configured laboratory space and a security and access control system;

- Established OCME as an Executive Branch agency, separating it from Department of Health, where the agency did not receive proper attention or budget;
- Increased the budget and staffing, with particular progress recently in filling positions;
- Created a 24-hour per day Communications Unit for case intake and agency contacts;
- Created an Investigations Unit staffed by Medicolegal Investigators who are medical professionals dedicated to the mission of OCME. (Note that this investigative agency never before had internal, professional investigators to serve its own mission. OCME relied on the police, or expected the physician medical examiners to carry this burden themselves.)
- Supported the creation of a unique grief and bereavement counseling service offered at OCME by the Wendt Center for Loss and Healing, recognized experts in this field;
- Established the position of OCME General Counsel, a function needed on a daily basis that never existed previously;
- Improved the quality of the professional output of OCME, including cause of death formulations and courtroom testimony, which has been noted by external entities relying on the OCME "product;"
- Provided training to various entities, most notably very active participation in the MPD Homicide School;
- Procured new equipment including autopsy tools, microscopes, laboratory instruments, communications devices (cell phones and radios) and a fleet of new vehicles;
- Consolidated fatality review functions in one facility, under the management of one agency, including establishing the new MRDDA Fatality Review Committee;
- Participated in disaster and emergency planning, both in the Mayor's Emergency Preparedness Council and in the Council of Government's Bioterrorism Task Force;
- Re-opened the internal toxicology laboratory, a core component of the agency, which had been closed since 1996, not only delaying results but forcing reliance on contracted services;
- Virtually eliminated the backlog of laboratory testing needed to complete cases;
- Installed and upgraded a functional local-area network (LAN) with particular improvements in the IT environment in the past year, including moving the OCME server to the OCTO shared data center, for security and management efficiency; and
- Have purchased and customized an automated case tracking/management system, which is well into implementation now, and which is the first ever modernization of the manual OCME business process.

The next concern I must raise is that throughout the report, OCME is being compared to and held accountable to the standards for accreditation by the National Association of Medical Examiners (NAME). NAME Accreditation is a desirable achievement for a medical examiner office. In fact, it has been one of my stated long-term goals to have OCME become NAME accredited. This process takes considerable time, effort and expense, even for an office that is functioning well and is stable; it is that much more difficult (and unreasonable, in a practical sense) for any office in transition. Remember that this is a strictly voluntary process, and that many major medical examiner offices are not accredited (for example New York City, St. Louis, Miami-Dade County, Delaware and Wayne County [Detroit], MI). To use these standards as insights to best practices is reasonable, but to expect the District's OCME to meet them all at this time is not;

there is no denying that in the process of transforming this organization, we have not achieved that level yet. As I stated above, there is more work to be done.

Another theme throughout the report is the absence of written policies and procedures at OCME. I certainly acknowledge the importance of having written policies to govern the functions of the agency. During my time as Chief Medical Examiner, I have expressed the desire to write a comprehensive policy manual for the agency. My managers and I have made plans and attempts to do so, and have issued various policy memos and some formal policy documents; others remain in draft form. These efforts have been derailed by the day-to-day needs to manage an agency with a very small administrative staff, exacerbated by vacancies in key executive positions. When the new Chief of Staff came on board six months ago, her first priority was to spearhead the creation of a policy and procedure manual. This goal has not been realized, since she has been overwhelmed from the start, largely by facilities issues, which are clearly of high priority both for the OCME staff and the public who visit us daily. (Before coming to the District, I worked at the New York City OCME, which although a premier office now, was undergoing the same kind of transformation then. Their first comprehensive policy and procedure manual was issued about six years into the administration of the new Chief ME.)

At the time of the inspection, the agency was not able to provide copies of written policies concerning important issues. Since that time, renewed searches of files have revealed prior policy memos, as well as drafts of policies not yet issued. Some of these address the more important issues raised in the report, such as infection control measures (universal precautions). While draft policies are not yet in effect, I attach those to illustrate the work in progress by the agency. The documents attached address issues raised in the draft report, including:

- Infection control (universal precautions);
- Use of instant photos for identification;
- Communications unit duties and functions;
- Organization of case files;
- Presentations at morning triage meetings;
- High-profile cases;
- Mortuary procedures;
- Personal property (one issued in August 2003, and one draft); and
- Privacy of confidential information (draft).

In addition, I attach copies of radiation monitoring reports which could not be located during the inspection, and computer screen prints from the automated tracking system ("FACTS") now in implementation, to show the procedures and training related to Communications, Transcription, Medical Records and Mortuary.

I must note my concern on another phenomenon in the draft report. I have made comments within the body of the report on multiple sections where the authors rely on uncritical reporting of staff complaints to form findings and conclusions of deficiencies in OCME. There are examples of comments that are untenable, and on occasions medically unsound, but which are repeated and adopted in the report, thus legitimizing them. Other instances give weight to staff assertions regarding personnel actions that are nothing more than speculations and rumors. The facts supporting personnel actions comprise protected information which cannot be revealed in

any public response, facts which are also unavailable to those making the assertions. Simply including their statements without comment or context is neither fair nor balanced.

Thank you for the opportunity to review and respond to the draft report. (Thank you also for the extension of time to prepare my response, which has allowed me to give it the attention it deserves.) I have made many comments within the body of the report, both on the text and the recommendations, which I will not attempt to repeat or summarize here. Suffice it to say that I feel strongly that some sections do not represent fairly the status of the agency, some conditions noted at the time of the inspection have been adequately addressed before the issuance of this draft report, and that other recommendations for change at OCME are correct and necessary.

Please contact me if I can provide any further assistance to your office regarding this report.

Sincerely,

Jonathan L. Arden, MD
Chief Medical Examiner